# OHIO'S PLAN OF SAFE CARE TOOLKIT

SEPTEMBER 1, 2022

# Table of Contents

The Governor's office continues to support the implementation of the Practice and Policy Academy goals and Ohio is dedicated in moving this work forward by developing a plan to better serve pregnant and postpartum women with substance use disorders and their infants and families.

This toolkit was prepared by the Practice and Policy Academy team members:

- Children and Family Futures
- Ohio Department of Mental Health and Addiction Services
- Ohio Department of Health
- Ohio Department of Job and Family Services
- Ohio Department of Developmental Disabilities
- Ohio Department of Medicaid
- Ohio Perinatal Quality Collaborative
- Supreme Court of Ohio
- Cincinnati Children's Medical Center
- Ohio Hospital Association

The Practice and Policy Academy's focus is to guide Ohio as we continue to implement the Comprehensive Addiction and Recovery Act (CARA) of 2016 and Plan of Safe Care (PoSC) to ensure legislative mandates are met. Creating a broad, public, shared vision for responsibility and ownership of PoSC by community partners will aide in the support of the infants and families affected by substances. The goals of the Ohio Practice and Policy Academy is to collectively:

1) Align interpretations of CARA and PoSC
2) Create cross-system training opportunities
3) Create a system for cross agency communication
4) Establish multi-system processes and procedures for PoSC
5) Monitor outcomes and data

## INTRODUCTION

The Comprehensive Addition and Recovery Act (CARA) was signed into law on July 22nd, 2016, with the purpose of addressing the opioid epidemic via prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal. Its provisions involving child protection amended the Child Abuse Prevention and Treatment Act (CAPTA). CARA legislation requires that states and their communities develop and implement multi-system monitoring systems as best practice in supporting pregnant people, affected infants, and their families. These monitoring systems are Plans of Safe Care (PoSC), which are used to determine whether and in what manner local entities are providing, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver. State agencies are now required to ensure a PoSC is in place for infants affected by substances and requires services to be identified for their parents and/or caregivers. Increased monitoring and oversight by states are required to ensure PoSC are implemented and that families have access to appropriate services.

This Toolkit has been prepared to guide Ohio's implementation efforts in establishing consistent processes and procedures for Plans of Safe Care. Establishing a coordinated, multi-system approach best serves the needs of pregnant women with substance use disorders, their infants, and their families. Collaborative

planning and implementation of services that reflect best practices for treating substance use disorders during pregnancy are yielding promising results in communities across the county. Our goal in Ohio to is reach these families and set the tone for long term positive results.

## SCOPE OF THE PROBLEM IN OHIO

### Opioid Use Trends

Over the last two decades, the nation has experienced an increase in opioid use disorders among women who are pregnant, which has increased the rate of Neonatal Abstinence Syndrome (NAS) and Neonatal Opioid Withdrawal Syndrome (NOWS) among infants.

The Centers for Disease Control and Prevention (CDC) found that 6.6% of pregnant women reported using prescription opioids during pregnancy in 2019. Based on this CDC study and the number of live births (n= 136,832) in Ohio in 2017, approximately 9,000 pregnant women in Ohio report using prescription opioids in a year. Ko, J.Y., D'Angelo, V.D., Haight, S.C., Morrow, B., Cox, S., Salvaesen von Essen, B., Strahan, A.E., Harrison, L., Tevendale, H.D., Warner, L., Kroelinger, C.D., Barfield, W.D. (2020). Vital Signs: Prescription Opioid Pain Reliever Use During Pregnancy-34 U.S. Jurisdictions, 2019. The Annie E. Casey Foundation, 2020. Kids Count Data Center.

### Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome (NAS) is the term used to represent the pattern of effects that are associated with opioid withdrawal in newborns (Hudak & Tan, 2012). NAS symptoms are affected by a variety of factors, including the type of opioid the infant was exposed to, the point in gestation when the mother used the opioid, genetic factors, and the exposure to multiple substances (Wachman, Hayes, Brown, Paul, Harvey-Wilkes, Terrin, Huggines, Aranda, & Davis, 2013). To assess the severity of the infant's symptoms, a scoring system, such as the Finnegan Neonatal Abstinence Scoring System or the Lipsitz Neonatal Drug-Withdrawal Scoring System is used. The results of the scoring system are used in conjunction with an assessment of other factors, including the infant's gestational age, overall health, medical history, exposure to other substances, and tolerance or response to medications, to determine the course of treatment (Jansson, Velez, & Harrow, 2009).

### Medication Assisted Treatment

Infants experiencing NAS are at an increased risk of harm because of maternal substance use, this risk increases when pregnant women abruptly discontinue use. The withdrawal from substances should be conducted under medical care, with physicians experienced in perinatal addiction (Kaltenbach, Bergella, & Finnegan, 1998). Medication assisted treatment (MAT) is recommended instead of withdrawal or abstinence (Jones, O'Grady, Malfi, & Tuten, 2008). MAT is the use of medications in combination with counseling and behavioral therapies to provide a whole-patient approach to the treatment of substance use disorders (SAMHSA, 2014a). Patient care is clinically driven and focuses on individualized patient care.

The medications which are used primarily to treat opioid use disorders include methadone and buprenorphine. Both medications stop and prevent opioid withdrawal and reduce cravings, which allows individuals to focus on other aspects of their recovery.

Ohio Department of Health

# 2020 Ohio Neonatal Abstinence Syndrome Report

## Table 1: Hospitalizations* Among Ohio Resident Newborns for Neonatal Abstinence Syndrome**, 2016-2020

| Neonatal Abstinence Syndrome | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Neonatal Abstinence Syndrome inpatient discharges | 2,223 | 1,935 | 1,932 | 1,675 | 1,652 |
| Medicaid Discharge | 1,986 | 1,753 | 1,738 | 1,548 | 1,516 |
| Non-Medicaid Discharge | 237 | 182 | 194 | 127 | 136 |
| Average length of days (LOS) in days | 12.9 | 13.4 | 12.7 | 12.3 | 13.2 |
| Total LOS (days) | 28,656 | 25,954 | 24,459 | 20,549 | 21,832 |
| Average charge*** | $61,598 | $65,127 | $69,257 | $69,187 | $82,948 |
| Total charge*** | $136,932,674 | $126,020,134 | $133,805,842 | $115,888,822 | $137,029,817 |

*Hospitalizations occurred in Ohio hospitals to Ohio residents

**NAS reflects ICD-10-CM code P96.1 (codes could be in primary or 18 secondary dx fields)

***Charges reflect charges billed by the hospital

## Table 2: Births* to Ohio Residents in Ohio Hospitals, 2016-2020

| Hospital Births | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Hospital births inpatient discharges | 140,142 | 138,267 | 135,937 | 135,487 | 129,890 |
| Medicaid Discharge | 63,792 | 64,808 | 63,165 | 63,294 | 60,962 |
| Non-Medicaid Discharge | 76,350 | 73,459 | 72,772 | 72,193 | 68,918 |
| Average LOS (days) | 3.7 | 3.8 | 3.8 | 3.8 | 3.7 |
| Average charge** | $16,695 | $17,812 | $18,952 | $20,525 | $21,810 |

*Hospital births reflect MSDRG codes 789-795 (Neonates and Newborns)

**Charges reflect charges billed by the hospital

## Table 3: Hospitalizations* Among Ohio Resident Newborns Associated with Exposure to Noxious Substances** through the Placenta or Breast Milk, 2019-2020

| Noxious Substance Exposure | 2019 | 2020 |
|---|---|---|
| Cocaine | 519 | 460 |
| Opioids | 876 | 1,018 |
| Sedative-hypnotics | 21 | 23 |
| Anxiolytics | 16 | 17 |
| Other drugs of addiction | 1,555 | 1,641 |

*Hospitalizations reflect MSDRG codes 789-795 (Neonates and Newborns)

**Cocaine exposure reflects ICD-10-CM code P04.41; Opiate exposure reflects ICD-10-CM code P04.14; Sedative-hypnotic exposure reflects ICD-10-CM code P04.17; Anxiolytic exposure reflects ICD-10-CM code P04.1A; Other drugs of addiction reflects ICD-10-CM code P04.49 (codes could be in primary or 18 secondary dx fields)

## Table 4: Ohio Health Outcomes* in Inpatient Settings, NAS Infants** vs. All Infants***, 2016-2020

| Health Outcome | 2016 | | 2017 | | 2018 | | 2019 | | 2020 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | NAS Infants | All Infants | NAS Infants | All Infants | NAS Infants | All Infants | NAS Infants | All Infants | NAS Infants | All Infants |
| Feeding Difficulties | 16.1% | 5.8% | 18.4% | 6.4% | 18.8% | 6.5% | 21.4% | 7.2% | 24.8% | 7.3% |
| Low Birth Weight | 15.6% | 9.4% | 19.0% | 10.6% | 18.3% | 10.6% | 18.1% | 10.9% | 19.9% | 11.0% |
| Respiratory Symptoms | 17.6% | 1.1% | 22.5% | 11.1% | 23.0% | 11.2% | 23.7% | 12.0% | 25.0% | 12.0% |
| Seizures & Convulsion | 0.7% | 0.2% | 1.1% | 0.2% | 1.2% | 0.3% | 0.5% | 0.3% | 1.2% | 0.2% |

*Health Outcomes reflect select ICD-10-CM codes (codes could be in primary or 18 secondary dx fields)

**NAS infants reflect ICD-10-CM code P96.1 (codes could be in primary or 18 secondary dx fields)

***All infants reflect MSDRG 789-795 (Neonates and Newborns)

Data Source: Ohio Hospital Association

## OHIO PROGRAMS

### The Department of Developmental Disabilities (DODD)

Early Intervention (EI) is a statewide system which provides coordinated early intervention services to parents of eligible children under the age of three years old with developmental delays or disabilities. Early Intervention is grounded in the philosophy that young children learn best from familiar people in familiar settings. Every family served in EI will have a local EI team that consists of a service coordinator, service providers, and the family. The EI team works with eligible families in their own home or other places they spend time to develop a coordinated plan called an Individualized Family Service Plan (IFSP). The team will work through the IFSP plan to use existing supports and resources and build upon them to learn to enhance the child's learning and development. In State Fiscal Year 2020 there were 23,349 children receiving EI services and supports.

In Ohio, a baby who has a confirmed diagnosis of NAS/NOWS is automatically eligible for EI. Early Intervention professionals support families to identify strengths and needs and address concerns as early as possible, with services right where families live, play, and spend their day.

Early Intervention can support families with children with NAS/NOWS by:

- Helping with any concerns regarding the baby's development,
- Helping provide the best learning environment for the baby that fits in with the family's daily routines and activities,
- Supporting families through the challenges many babies born with NAS/NOWS have with feeding, learning, sleeping, and playing with others; and
- Connecting families to resources for mental health, medical care and other supports and services.

Any baby diagnosed with NAS/NOWS is eligible for Ohio Early Intervention. The parent, healthcare providers, or anyone can refer to EI. The process is simple. Contact **1-800-755-GROW** or fill out the online form which can be found at: Help Me Grow Referral (ohio.gov)

### The Maternal Opiate Medical Support Program in Ohio

Maternal Opiate Medical Supports (MOMS): The MOMS program is Ohio's response to the growing needs of pregnant women with opioid use disorder. The MOMS maternal care home is a set of evidence-based practices that emphasize a team-based delivery model with care coordination, provision of wrap-around services, and engaging the women in medication-assisted treatment (MAT) and case management. MOMS teams are led by care coordinators who ensure communication between the clients and program partners is consistent, no matter whether that partner be an obstetrician, behavioral health provider, or some other entity. Funded MOMS programs participate in training and technical assistance events, learning communities, co-locating OB/GYN services, and coordinating with managed care plans and other entities (e.g., accountable care organizations (ACOs), comprehensive primary care centers (CPCs), and federally qualified health centers (FQHCs) to encourage program sustainability.

Plans of Safe Care are easily integrated into MOMS programs or similar maternal health programs. Traditionally, MOMS programs host one of more meetings for women in the third trimester with one staff member from the local public children services agency. These meetings discuss the role of child welfare

after delivery of the baby and the ways in which local child welfare staff can provide additional resources for the family. This is an opportunity for mothers-to-be to ask questions that can help address their fears and concerns about the involvement of child welfare in their pregnancy. Small communities, in which patients often personally know child welfare staff, have benefited from presenting letters delivered by staff from the treatment agency with anonymous questions. The outcome of these formal and informal meetings can result in significantly less stress from mothers-to-be about the notification process. Many of these meetings have also encouraged women in treatment to develop binders documenting their recovery journey and healthcare contacts, so that the local child welfare staff can "screen out" a referral (not have a need for an assessment/investigation) when they are notified after the baby's delivery.

## SUPPORTING POLICY AND PRACTICE

The National Child Abuse and Neglect Data System (NCANDS) requires the following data to be reported yearly:

1. The number of infants identified as being affected by substance use, withdrawal symptoms as a result from prenatal substance exposure, and/or a diagnosis of FASD
2. The number of infants for whom a PoSC was developed
3. The number of infants for who referrals were made for appropriate services, including the services for the affected family or caregiver.

CARA legislation required ODJFS to define the following terms, including the Plan of Safe:

- An **infant** is defined as a child under the age of 12 months.
- A **substance exposed** infant is a child under the age of 12 months who has been subjected to legal or illegal substance use while in utero.
- A **substance affected** infant is a child under the age of 12 months who has any detectable physical, developmental, cognitive, or emotional delay or harm which is associated with a parent, guardian, or custodian's (P/G/C's) use of a ***legal or illegal*** substance; excluding the use of a substance by a P/G/C as prescribed.
- A **Plan of Safe Care** describes the services and supports to comprehensively address the needs of infants prenatally exposed to substances, both ***legal and illegal***, and their families. These federally required plans should identify all family members and any caregiver living in the home who is affected by substance use. The PoSC should incorporate all treatment plans developed by the multidisciplinary professionals serving the family, including substance use disorder treatment services, developmental interventions for the infant, and services and supports needed to promote family stability. The plan should be developed with the family's input. It is important to note the involvement of a Public Child Services Agency (PCSA) is not required for a PoSC to be in place.

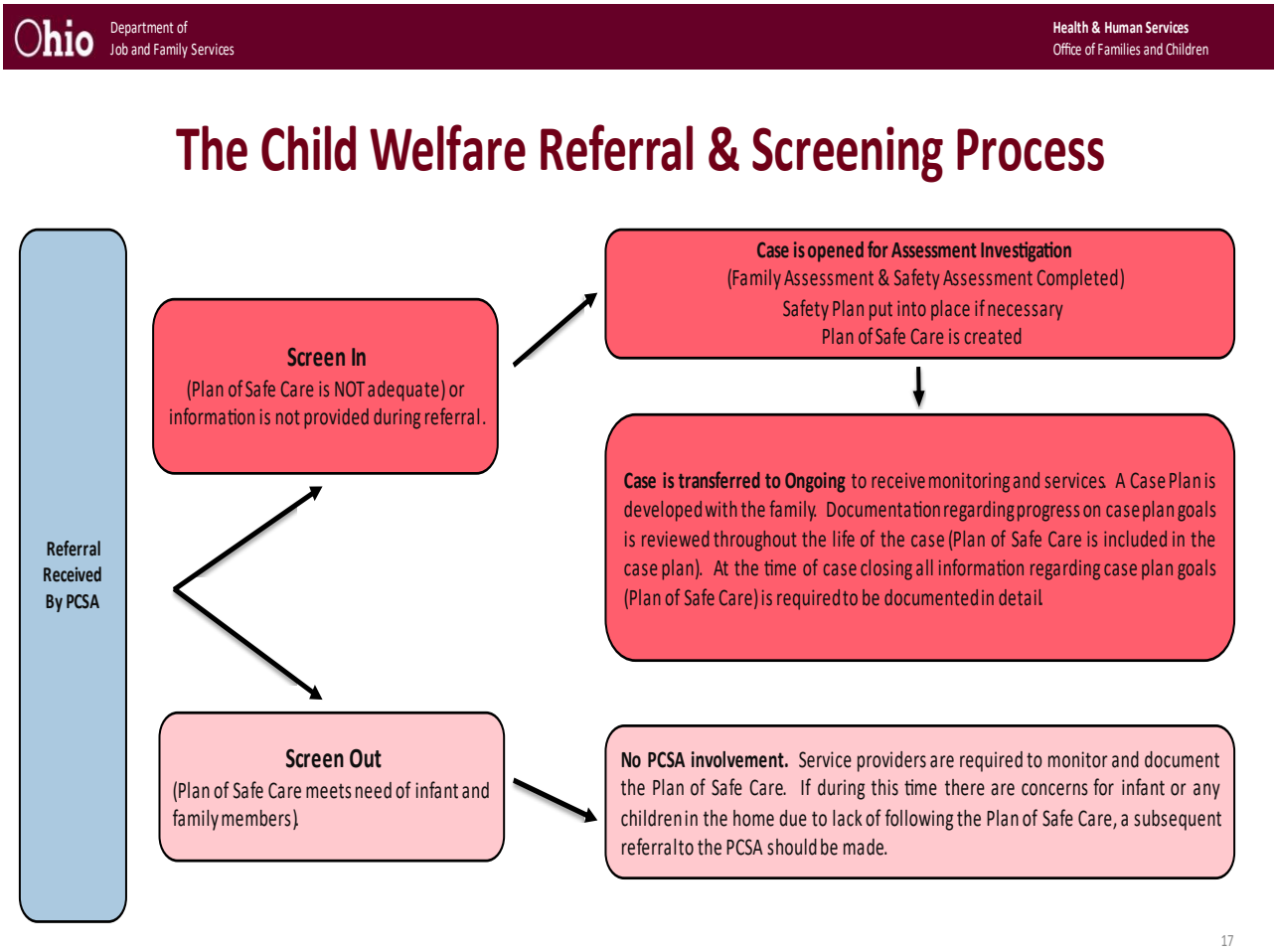
## CHILD WELFARE – MANDATED REPORTERS, REFERRALS, AND THE SCREENING PROCESS

The expectations for mandated reporters; referenced in ORC 2151.421 – require a referral to child welfare when an infant is impacted by the misuse of legal or illegal substances. Per Ohio law a referral needs to be made anytime:

- Mother or infant test positive for an illegal substance, non-prescribed substance and/or misused prescribed controlled substance.
- Infant is exhibiting signs of withdrawal because of prenatal exposure to an illegal substance, non-prescribed substance and/or misused prescribed controlled substance.
- Infant is diagnosed with Fetal Alcohol Spectrum Disorder.

When a referral is made involving an infant who has been identified as being substance exposed, CARA legislation federally requires PCSAs to gather additional information, such as documentation of the PoSC, how the PoSC addresses the safety needs of the infant, and how the PoSC addresses the health and substance use disorder treatment needs of the affected family member or caregiver.

PCSAs are federally required to screen in referrals for assessment/investigation if the PoSC is not in place and/or the PoSC information is not available or adequate at the time of the referral. Therefore, the mandated reporter providing as much detail as possible about the family's PoSC at the time of the referral could potentially prevent the family from being unnecessarily involved with the child protection system.



## BEST PRACTICES FOR PLANS OF SAFE CARE

As introduced earlier, in May 2020 The National Center on Substance Abuse and Child Welfare facilitated a six-month Practice and Policy Academy to improve outcomes for pregnant and parenting women with opioid use disorder, Ohio was selected as one of the states to participate, and the multi-system team who attended continues to meet in an ongoing way to improve practices across the state. Members include the Ohio Department of Mental Health and Addiction Services (OHMAS) serving as the lead partner and representatives from the Ohio Department of Mental Health and Addiction Services (OHMAS) serving as the lead partner. The academy is comprised of representatives from: Ohio Department of Mental Health and Addiction Services (OHMAS), Ohio Department of Job and Family Services (ODJFS), Ohio Department of Health (ODH), Ohio Department of Developmental Disabilities (DODD), Ohio Department of Medicaid (ODM), Supreme Court of Ohio (SCO), several large hospitals (Ohio State University & Cincinnati Children's Medical Center), Ohio Perinatal Quality Collaborative (OPQC), and several representatives from Ohio's PCSAs.

The goals of the Ohio team are to provide consistent education, training, and implementation strategies on PoSCs by addressing the needs of pregnant and postpartum women with substance use disorder:

A PoSC describes the services and supports to comprehensively address the needs of infants prenatally exposed to substances, both legal and illegal, and their families. These federally required plans should:

- Be created prenatally with the family whenever possible;
- Identify all family members and any caregiver living in the home who is affected by substance use, and
- Incorporate all plans developed by the multidisciplinary professionals serving the family, including substance use disorder treatment services, developmental interventions for the infant, and services and supports needed to promote family stability.

It is critical that we work together to build multi-disciplinary collaborative teams to implement and monitor PoSC for all infants affected by substances in Ohio, including infants who are never involved with the child protection system or whose child protection involvement has ended. PoSC are required to be implemented, monitored, and evaluated for all infants affected by substances and their parents and/or caregivers, including families who are not involved with the child protection system.

Multi-agency collaborative teams are needed to develop prevention strategies for families not involved in the child protection system, and to ensure that families have access to appropriate services. Prevention strategies can include prenatal PoSC policies and practices that involve health and social services agencies outside of child protection to support families for whom there are no identified concerns of child maltreatment.

## COMPREHENSIVE FRAMEWORK FOR INTERVENTION

Decisions regarding pregnant women with substance use disorders involve many different systems, which can include health care providers, child welfare, substance use treatment providers, various community providers, and the justice system. The processes and procedures of these systems and the work they do stem from federal regulations, state legislation, ethics, and system-specific guidelines. The education and

training of these partners is paramount to ensuring directives align with positive outcomes for the infants, mothers and families identified as being impacted by substance use.

The most effective strategies for supporting families include addressing issues beyond just substance use, which can include mental health issues, trauma, family and friend relationships, economic issues, and other stressors. CARA is specific and intentional as the legislation includes the infant, mother and any other caregiver of the infant who is impacted by substance use. Implementation of process and procedures for PoSC should be family focused and culturally responsive.

The five-point intervention framework developed by the National Center on Substance Abuse and Child Welfare (NCSACW) and funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Administration on Children, Youth and Families, serves as a comprehensive model that identifies five major time frames when intervention in the life of an infant can help reduce the potential harm of prenatal substance exposure (Young et al., 2009).

The five-point framework focuses on opportunities for strengthening interagency efforts that address prevention, intervention, identification, and treatment of complications related to prenatal substance exposure. The focus is on immediate and ongoing services for infants, mothers, and families. The birth of an infant is only one point in time, and it is important to understand where there are opportunities to effectively impact long term positive outcomes.

**5 Points of Family Intervention:**

| Pre-Pregnancy | Prenatal | Birth | Neonatal, Infancy & Postpartum | Childhood & Adolescence |
|---|---|---|---|---|
| Focus on preventing substance use disorders before a woman becomes pregnant through promoting public awareness of the effects of substance use (including alcohol and tobacco) during pregnancy and encouraging access to appropriate substance use disorder treatment | Focus on identifying substance use disorders among people who are pregnant through universal screening and assessment, engaging them into effective treatment services, and providing ongoing services to support recovery | Focus on identifying and addressing the needs of infants affected by prenatal substance exposure, withdrawal symptoms, and Fetal Alcohol Spectrum Disorder including the immediate need for bonding and attachment with a safe, stable, consistent caregiver | Focus on ensuring the infant's safety and responding to the needs of the infant, parent, and family through a comprehensive approach the ensures consistent access to a safe, stable caregiver and a supportive early care environment | Focus on identifying and responding to the unique developmental and service needs of the toddler, preschooler, child, and adolescent who was prenatally exposed through a comprehensive family-centered approach |

## COLLABORATIVE PARTNERSHIPS FOR PLANS OF SAFE CARE

A multi-agency collaborative team can ensure that a flexible approach for PoSC is developed to accommodate the specific needs and risk levels identified with each family. Foundational elements to build, grow, and sustain a collaborative team include the choice of structure and identification of key partners. They are discussed in detail, as follows:


### Establishing a Collaborative Structure

A strong collaborative structure includes an oversight committee, a state leadership core team, and work groups that may include local implementation teams. The oversight body ensures that the initiative is a priority for affecting policy and practice changes. The state leadership core team creates, directs, and evaluates strategies for systems change. Federal and state policy guides work groups and local implementation teams to test and implement practice changes.

Ohio currently has established an oversight committee through the Practice and Policy Academy, which as mentioned earlier is funded through Children and Family Futures, with OHMAS serving as the lead agency for Ohio's agencies and providers who serve this population.

### Role of the Work Groups and Implementation Teams

Work groups and implementation teams are key to helping service delivery systems translate state laws, policies, and guidance into practice. They accomplish this by developing and pilot testing practice changes, communication protocols, and information-sharing processes to ensure that child and family-focused service delivery systems are well coordinated and meet quality standards. The delivery systems encompass prevention, early intervention, maternal and infant health care and an array of community-based treatment and support services for infants, children, and their families or caregivers. Implementation teams can determine the range of services each family needs, the services that are currently available, gaps in the services available, and how to address the gaps. Teams should address practical implementation issues, such as the following:

- What information should the PoSC include?
- How will professionals share information in the PoSC while ensuring compliance with confidentiality regulations?
- In what format is the PoSC (hard copy or electronic)?
- Should the client's medical record include the PoSC?

- What role does each system play in serving this population of infants and their families? For example, which partner implements prevention strategies and which partner develops a PoSC?
- Can the team identify current practices that may be contributing to disproportionality in child welfare?

**Engage Necessary Partners & Identify Strategies**

Ideally, both the state leadership core team and the work group/local implementation team includes the array of family-serving agencies that provide services and supports to address the health and substance use disorder (SUD) treatment needs of the infant and affected family or caregiver and implement the other provisions in The Child Abuse Prevention and Treatment Act (CAPTA) related to developing Plans of Safe Care.

A Substance Use Disorder (SUD) is a medical condition that is defined by the inability to control the use of a particular substance (or substances) despite harmful consequences. (American Psychiatric Association. (2020, December). *Help with addiction and substance use disorders*). In other words, SUDs occur when an individual compulsively misuses drugs or alcohol and continues abusing the substance despite knowing the negative impact it has on their life. (American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing) & (Substance Abuse and Mental Health Services Administration. (2020, April 30). Mental health and substance use disorders).

## COLLABORATIVE TEAM REPRESENTATIVES MAY INCLUDE:

- Public Health
- Maternal and Child Health
- Home Visiting
- SUD prevention and treatment
- Mental health
- Community-Based Child Abuse Prevention
- Child Protective Services (CPS)
- Early intervention and developmental services
- Courts
- Education
- Budget and finance
- Medicaid and private insurance
- Hospitals and hospital associations
- Medical providers, such as obstetricians and pediatricians

SUDs may range from mild to severe, with severity depending on the number of diagnostic criteria a person meets. When someone is diagnosed with mild SUD, this means a person displays 2-3 symptoms, moderate means they display 4-5 symptoms, and severe means they display 6 or more. (American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing). The American Psychiatric Association (APA) has developed 11 criteria for SUD diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*.

The DSM-5 Criteria for Substance Use Disorders includes:

- Taking the substance for long periods of time or in larger amounts than intended.
- Being unable to cut down or stop substance use.
- Spending a lot of time obtaining, using, and recovering from the effects of the substance.
- Experiencing cravings, or intense desires or urges for the substance.
- Failing to fulfill obligations at home, work, or school due to substance use.

- Continuing substance use despite having interpersonal or social problems that are caused or worsened by substance use.
- Giving up social, recreational, or occupational activities due to substance use.
- Using the substance in risky or dangerous situations.
- Continuing substance use despite having a physical or mental problem that is probably due to substance use.
- Tolerance, or needing more of the substance to achieve previous effects.
- Withdrawal, meaning that unpleasant symptoms occur when you stop using your substance of choice.

Finally, it is helpful to have members on the team with expertise in financing and budgeting to identify funding resources and strategies to support practice changes that have fiscal implications. Team members are expected to access the leadership of their respective agencies to facilitate the teams' decision-making.

To determine which partners should be involved in the initiative, it is helpful to map partner agencies services' array available to infants, children, and families. This exercise provides a foundation for identifying practice changes that may include improving access to existing services, expanding existing services, developing new services, and coordinating care among these family-serving agencies. Collaborative teams should assess which partners are missing and are critical to address the needs of infants, families, or caregivers affected by prenatal substance exposure.

**Define Shared Goals**

Every state, tribe, and community are supported and challenged by its own systems' mission, issues, beliefs, and values. On occasion, the existing protocols, culture, and financial constraints may affect the collaborative team's ability to successfully coordinate their approach and share accountability for the outcomes. Therefore, each team member should evaluate how their system-specific and individual principles and values will inform practice and policy change and understand the perspectives that are influencing the positions and decisions of the other partners. Each member of a newly formed team benefits from fact gathering and sharing to garner an understanding of:

- Practices and policies in all team members' service systems
- Partner mandates and priorities that are likely to affect, and possibly limit, their level of involvement
- The terminology that each team member's organization uses most often and how the organizations define these terms (e.g., "treatment," "screening").

**Identify Strategies and Jointly Monitor Outcomes**

A shared understanding of how partner agencies provide services and supports to this population is a crucial component of developing a coordinated, community based PoSC approach. Team members must engage in ongoing knowledge transfer and share information to identify existing and new strategies, including evidence-based and evidence-informed practices and supports for pregnant women with SUDs and their infants from a multi-system perspective. Sharing information provides the foundation for the team to:

- Consider the desired outcomes for families in each system by:
    - Determining how success is defined and measured

    - Identifying baseline levels for clients, including disparate outcomes for minority and other populations
    - Exploring the availability of better (or additional) indicators that can demonstrate progress
- Determine the metrics that need to be developed and tracked to effectively measure success for these families over time. An example of a metric is the number of pregnant women treated with medications for addiction treatment. This work can include assessing the technology available to track outcomes.
- Create a method for communicating progress related to key indicators to ensure transparency and promote accountability for results. Methods for communicating progress include cross-system report cards or dash boards.
- Create a plan to determine which changes need to be sustained and how the team will document, maintain, and build on the collaborative team's institutional knowledge, which is gathered through the metrics.

**Questions to Discuss with Your Collaborative Team**

- What is each represented agency's role in achieving shared priorities and outcomes?
- What types of authority does each need for their agency to contribute to the team?
- What initiatives or strategies are partner agencies implementing to support infants and families affected by prenatal substance exposure?
- What does each team member understand and believe about the nature of substance use and SUDs, particularly as it relates to pregnant and parenting women?
- What do team members understand and believe about recovery?
- What do team members or policy leaders understand and believe about the use of medication-assisted treatment for women who are pregnant or breastfeeding?
- What do team members agree to be the markers of effective practice and service delivery?
- How can state and implementation teams use this work to change the stigma around substance use during pregnancy to support healthy decision making and receipt of appropriate interventions that also ensure the safety and well-being of the infant or child and the family/caregivers?
- Is there over-representation of minorities in child welfare and under-representation in SUD treatment and other family support services?
- What improvements can current systems and services target, especially from the perspective of mothers, children, and family members, to provide essential care?
- Which key stakeholders are missing from the conversation?

**Key Implementation Considerations**

Integrating with Current Work Groups, Coalitions, and Taskforces Initiatives already working with this population may include local health departments with maternity programming, perinatal quality collaboratives, opioid task forces, or maternal mortality review boards. These entities can provide guidance on their respective roles in supporting infants and families during the prenatal period, birth, postpartum, and early childhood. They can also help ensure that statewide and regional initiatives are coordinated to complement rather than duplicate efforts.

### Creating a New Collaborative Team or Enhancing Existing Partnerships

Jurisdictions that have a long history of collaboration and developing cross-system policy among public health, SUD treatment, and child welfare can benefit from focusing efforts on:

- Building collaborative relationships with maternal and infant health care providers, hospitals, public health, and early intervention providers
- Expanding communication channels
- Developing services to support parents with SUDs and infants affected by prenatal substance exposure
- Codifying cross-system policies and practices

Communities without a history of cross-system collaboration may benefit from creating a structure and identifying collaborative partners. Initial tasks should focus on establishing shared values and goals and identifying areas for system improvement.

### Thinking Beyond Child Welfare as the Lead Collaborative Agency

An array of government or nonprofit entities can also lead the development of Plans of Safe Care, particularly for families not involved with the child welfare system. There are strong models of co-leadership between two or more state agencies for Plans of Safe Care policy and practice development. Although child welfare agencies have primary responsibility for ensuring that families who are brought to their attention receive needed services and support, multi-disciplinary collaborative teams can develop prevention strategies for families not involved in the child welfare system. These strategies include prenatal Plans of Safe Care policies and practices that involve health and social services agencies outside of child welfare to support families for whom there are no identified concerns of child maltreatment. This approach may prevent referrals to child welfare that otherwise may have been reported in some jurisdictions.

When entities other than child welfare step into leadership roles, collaborative preventive approaches that integrate SUD treatment programs, healthcare, public health, and maternal and child health partners have emerged. The child welfare agency remains a critical partner and will be a primary resource for the highest risk families. State child welfare agencies are more successful in implementing a comprehensive collaborative approach to address the needs of infants affected by prenatal substance exposure and their affected family or caregivers when they fully engage partners to coordinate related initiatives, share subject matter expertise, and consider complimentary practice strategies to operationalize Plans of Safe Care.

## LOCAL IMPLEMENTATION EFFORTS

In several jurisdictions, which include Ohio's three QIC counties, Plans of Safe Care guidance policies have been developed and evaluated as expansion and education continue. The local jurisdictions are expected to report back to the state the implementation challenges and innovations they are experiencing, and this information shapes and informs state guidance.

Coshocton, Fairfield, and Trumbull counties formed Ohio's first three county implementation teams in April 2018, when they were three of only fifteen jurisdictions across the United States to be awarded the National Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT) grant. The

QIC-CCCT served as a national initiative to assist infants and families affected by substance use disorders and prenatal substance exposure. The Children's Bureau funded the initiative, which was operated by the Center for Children and Family Futures (CCFF) and its partners the National Center for State Courts (NCSC), Advocates for Human Potential (AHP), the Tribal Law and Policy Institute, and the American Bar Association Center on Children and the Law.

The grants were designed to link national and local experts to address the needs of infants impacted by substance exposure and their families. The nationally recognized experts provided individualized training and technical assistance to the Coshocton, Fairfield, and Trumbull County family courts and their partners to help them develop, implement, monitor, and evaluate new multi-systemic initiatives.

The QIC-CCCT's four main goals/outcomes were:

1. Implementation - to enhance the capacity of CCCTs to appropriately implement the provisions of CARA amendments to the Child Abuse Prevention Treatment Act (CAPTA).
2. Capacity – to enhance and expand CCCTs' capacity to effectively collaborate to address the needs of infants, young children, and their families/caregivers affected by substance use disorders and prenatal substance exposure.
3. Sustainability – to sustain the effective collaborative partnerships, processes, programs, and procedures implemented to achieve the goals of each demonstration site.
4. Dissemination – to provide the field with lessons they can apply about effective practices for implementing the requirements of CARA and meeting the needs of children and families affected by SUDs.

Coshocton, Fairfield, and Trumbull counties have all built collaborative provider teams, identified, and expanded the available resources in their counties, developed county specific PoSC documents, created processes for implementing and monitoring PoSC, educated their communities about PoSC and additional supports, and much more. They have been instrumental in informing the state's Practice and Policy Academy about opportunities and barriers that other jurisdictions are likely to face, as well as providing practical guidance as CARA work is expanding throughout the state. Tools and guidance documents created by other Ohio counties can be found on the Bold Beginnings Website, which can be accessed through the link provided in the Training and Technical Assistance or Quick Links sections below.

## TRAINING AND TECHNICAL ASSISTANCE

The Healthy Families Handbook was created by the Practice and Policy Academy and holds an abundance of trainings and information relevant to CARA/PoSC and supporting families identified with substance use issues. This handbook and additional educational resources can be found and on the Bold Beginnings website: Plans of Safe Care for Expectant Mothers | BOLD Beginning! (ohio.gov) and Plans of Safe Care | for Providers BOLD Beginning! (ohio.gov)

The purpose of the Healthy Families Handbook is to assist all community partners with understanding the implementation of CARA specifically Plans of Safe Care (PoSC). It was created to assist those professionals responsible for developing PoSC, specifically PCSAs and their community partners.

**Quick Links:**

- Ohio Department of Job and Family Services, Child Protective Services Division: Office of Families and Children | Ohio Department of Job and Family Services

- County teams may request technical assistance through the Bold Beginnings website, which can be accessed through the following link: Website: Plans of Safe Care for Expectant Mothers | BOLD Beginning! (ohio.gov) and Plans of Safe Care | for Providers BOLD Beginning! (ohio.gov)

- If your agency and community partners are interested in scheduling a training on the Comprehensive Addiction and Recovery Act/Plan of Safe Care, please contact the ODJFS Child Protective Services Unit at: Deanna.Herold@jfs.ohio.gov or Erin.Robey@jfs.ohio.gov (ODJFS offers this training both virtually or in person)

- If you have any questions regarding receiving assistance with substance use and/or creating a Plan of Safe Care during your pregnancy, please contact your local Child Welfare Office and request to be connected to the Intake Department. Each county Child Welfare Office can be found using this link: County Directory (ohio.gov)